



Dear Physician,

Thank you for working with this patient/client as they seek admission to the Aloha House Substance Abuse Treatment. Your role is extremely important for the patient/client to be admitted to Aloha House. We are a medically monitored detoxification and treatment program. We have nurses on staff and a Medical Director; however, **our license does not allow us to have admitting or prescribing physicians on staff. We rely on community physicians to fulfill this role.**

There are 6 pages attached and each one is vital to the admission. We have made them as quick and simple as possible for you. Please complete each page; there are also brief instructions on each page.

PLEASE FAX ALL COMPLETED FORMS TO ALOHA HOUSE AT (808) 579-8902.

1. **Release of Information:** Patient/client must initial and sign where indicated. Please fill in your name at top where indicated. This is vital; we cannot talk to you without this form in our hands.
2. **Physical History and Screening:** Simple questionnaire.
3. **Physical Exam**
 - a. Lab work as deemed appropriate.
4. **Physician Orders:**
 - a. Please check only one protocol and prescribe for the alcohol or drug detox orders.
 - b. If client uses both opiates and alcohol, please prescribe the priority protocol, the **opiate PRN protocol** may be added as appropriate.
 - c. Additionally, please prescribe Vistaril and Trazodone for all clients as indicated.
 - d. Prescribe any other medication the patient/client is currently taking except controlled substances.
5. **Standing Orders:** Self explanatory, please sign at the bottom.

Please give the prescriptions to the patient/client and/or call a pharmacy for all prescription orders. **The patient/client must pick up and bring in ALL medications needed, in order to be admitted into Aloha House.**

BEFORE RELEASING THE PATIENT/CLIENT, PLEASE FAX FORMS AND WAIT FOR THE NURSE TO CALL AND CONFIRM THE ADMISSION. AT THAT TIME THE NURSE MAY DISCUSS QUESTIONS ABOUT THE FORMS.

Thank you very much for your cooperation and please feel free to call if you have any questions.

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PHYSICAL EXAM SCREENING (PHYSICIAN COMPLETES)

Client Name: _____
Last Name First Name M.I.

➤ **Is the client presently under the influence of alcohol and/or other drugs?** (check one) YES or NO
If yes, what substances? _____

➤ **Is the client presently having withdrawal symptoms?** (check one) YES or NO
If yes, please describe withdrawal symptoms: _____

➤ **Does the client have a history of delirium tremors?** (check one) YES or NO

➤ **Any recent illnesses or diseases?** (check one) YES or NO
If yes, please describe: _____

➤ **Any injuries?** (check one) YES or NO
If yes, please describe: _____

➤ **Is the client taking any prescription medication?** (check one) YES or NO
If yes, please specify medications: _____

****NOTE: If client is to take these medications at Aloha House, please write these orders in at the bottom of the PHYSICIAN ORDER FORM.**

➤ **Has the client been hospitalized in the last year?** (check one) YES or NO
If yes, please describe: _____

➤ **Does the client have a psychiatric history?** (check one) YES or NO
If yes, please describe: _____
Any Medications? _____

➤ **Has the client been depressed recently?** (check one) YES or NO

➤ **Does the client have thoughts of harming self and/or others?** (check one) YES or NO

➤ **Is the client having auditory and/or visual hallucinations?** (check one) YES or NO

➤ **FEMALES ONLY: Pregnant?** (Please circle one) YES or NO
If yes, how many weeks/months pregnant? _____ Date of last menstrual period: _____

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PHYSICIAN ORDER FORM (To be completed by Physician)

Client Name (Please Print): _____

Examining Physician, please provide the orders and prescriptions for the following medications, if indicated.

DETOX ORDERS: Check **ONE** box below for appropriate detox orders, if necessary, and **prescribe medications listed.**

ALCOHOL WITHDRAWAL: Fixed-dose LIBRIUM. For clients with history of WITHDRAWAL SEIZURE or DELIRIUM TREMENS.
Librium 25 mg. #20, two PO Q6h X 4 doses, then one PO Q6h X 8 doses, then discontinue.
If CIWA Ar score > 10 on fixed-dose schedule, follow CIWA protocol for additional Librium doses.
Trazodone 50 mg. #15, one PO QHS PRN insomnia X 7 days. May repeat Q1h PRN until effective, NTE 350 mg. per night.
Vistaril 50 mg. #10, one PO Q4h PRN nausea or anxiety X 7 days.

-OR-

ALCOHOL WITHDRAWAL: CIWA-Based LIBRIUM.
Librium 25 mg. #10, two PO PRN for CIWA-Ar score > 10.
Trazodone 50 mg. #15, one PO QHS PRN insomnia X 7 days. May repeat Q1h PRN until effective, NTE 350 mg. per night.
Vistaril 50 mg. #10, one PO Q4h PRN nausea or anxiety X 7 days.

-OR-

OPIATE WITHDRAWAL PRIMARY: **OPIATE WITHDRAWAL PRN (USE IF ANOTHER SUBSTANCE IS PRIMARY):**
Clonidine 0.1 mg. #8, one PO on arrival and QID X 48 hours, hold if BP < 90/60. (Hold all clonidine if using Librium)
Clonidine Patch TTS-2 X 7 days, remove if BP < 90/60 or.
TTS-1 Patch if client weighs less than 110 lbs. .
Parafon Forte 500 mg. #10, one PO Q6h PRN muscle cramps X 7 days.
Trazodone 50 mg. #15, one PO QHS PRN insomnia X 7 days. May repeat Q1h PRN until effective, NTE 350 mg. per night.
Vistaril 50 mg. #10, one PO Q4h PRN nausea or anxiety X 7 days.

-OR-

BENZODIAZEPINE DETOXIFICATION

Administer Librium 25 mgs. P.O. Q 1 hr. PRN for withdrawal sx if 3 of 7 are present*

***NOTIFY DOCTOR IF NEEDED MORE THAN FOUR (4) HRS IN A ROW**

- | | |
|-----------------------|--------------------|
| 1. Systolic BP > 160 | 5. Nausea/vomiting |
| 2. Diastolic BP > 100 | 6. Tremors |
| 3. Heart rate > 110 | 7. Diaphoresis |
| 4. Temperature > 101 | |

Administer Gabapentin (Neurontin):

Neurontin 300 mg BID X 1 day then,

Neurontin 300 mg TID X 10 day then DC

Neurontin 300 mg p.o. q. 1 hr. p.r.n. for anxiety. NTE 900 mg in 24 hrs. Call MD if more needed.

Trazodone 50 mg. #15, one PO QHS PRN insomnia X 7 days. May repeat Q1h PRN until effective, NTE 350 mg. per night.

****Contact MD on 5th day after 1st dose of Neurontin for further assessment.**

-OR-

METHAMPHETAMINE DETOXIFICATION

Trazodone 50 mg. #15, one PO QHS PRN insomnia X 7 days. May repeat Q1h PRN until effective, NTE 350 mg. per night.

Vistaril 50 mg. #10, one PO Q4h PRN nausea or anxiety X 7 days.

PLEASE PRESCRIBE ANY OTHER MEDICATIONS THE CLIENT IS CURRENTLY TAKING, BY LISTING THEM IN THE AREA BELOW:

MD Printed Name _____ Date _____

MD Signature _____ Phone # _____

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**ALOHA HOUSE, INC.
Standing Orders**

Client Name: _____

1. **Multivitamin** w/o iron 1 PO QD length of stay.
2. **Folate 1 mg** PO QD x 3 days.
3. **Thiamine 100 mg** PO QD x 7 days.
4. **Vitamin C 500 mg** 1 tab PO QD length of stay.
5. **Loperamide 2 mg** 2 tabs (4 mg) PO STAT for diarrhea, then 2 mg (1 tab) after each loose stool (not to exceed 8 mg in 24 hours).
6. **Aspirin 325 – 650 mg** PO Q4 hours PRN minor aches, headaches, fever.
7. **Maalox/Mylanta 15-30 ml. or 1-2 tabs** p.o. q. 4-6 hrs. PRN. for GI discomfort
8. **Acetaminophen 500 mg** 1 – 2 PO Q 6 hours PRN general discomfort.
9. **Ibuprofen 400 – 600 mg** PO Q 4 – 6 hours with food PRN general discomfort.
10. **Milk of Magnesia 30-60 ml.** p.o. q. hs. With large glass of water PRN. for constipation
11. **Promethazine 25 mg** p.r. Q 4-6 hrs. p.r.n. nausea/vomiting
12. **Naproxen 220mgs** 1-2 tabs q.d. PRN x 3 days for severe pain **NTE 440mg in 24 hrs.**
13. **Chlorpheniramine 4 m.** p.o. BID PRN for up to 7 days for nasal congestion r/t colds/allergies
14. **Diphenhydramine 25 mg.** p.o. p.r.n. for acute allergic reaction. May repeat once for severe reaction.

ALLERGIES: _____

MD Printed Name _____ **Phone#** _____ **FAX#** _____

MD Signature _____ **Date** _____

Nurse Signature _____ **Date** _____

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